

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-045211

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

318

1003

11388

FILED NOV 22 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN St. Louis

Length of stay in 1b

1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE Missouri b. COUNTY

c. CITY OR TOWN

St. Louis

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION

Christian Hospital

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

1403 Angelica St.

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED (Type or print)

First

Otto

Middle

G.

Last

Benner

4. DATE OF DEATH

Month Day Year

Nov. 15, 1963.

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH

9/5/1889

9. AGE (last birthday)

74

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired-Maintainence

10b. KIND OF BUSINESS OR INDUSTRY

Lumber

11. BIRTHPLACE (City and state or country)

St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY

U S A

13a. FATHER'S NAME

Jacob Benner

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Elizabeth Benner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of)

No

16. SOCIAL SECURITY NO.

8

17. INFORMANT

Address

Mr. Harold G. Benner, 7708 Florentine

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Uremia

INTERVAL BETWEEN ONSET AND DEATH

10 Days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Cerebral artery thrombosis with hemaplegia on left.

DUE TO (c)

332x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

St. Louis

COUNTY

STATE

Missouri

21. I attended the deceased from July 14, 1959 to November 15, 1963 last saw him alive on November 15, 1963 Death occurred at 2 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Joseph A. Crutcher M.D.

22b. ADDRESS

2425 N. Broadway, St. Louis, Mo.

22c. DATE SIGNED

11/16/63

23a. BURIAL, CREMATION, REMOVAL (Specify)

removal

23b. DATE

11-18-63

23c. NAME OF CEMETERY OR CREMATORY

Memorial Park Cemetery

23d. LOCATION (City, town, or county)

St. Louis County

(State)

Mo.

24. FUNERAL DIRECTOR

ADDRESS

Drehmann-Harral, 1905 Union Bl.

25. DATE RECD. BY LOCAL REG.

NOV 18 1963

26. REGISTRAR'S SIGNATURE

Paul Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

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56

Dr. J. Costantino  
2425 N. Broadway  
CH 1-4455  
8-3 Sag.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

FORM 81 VOL.